Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Laura Barnard Crosskey**

 1709 Legion Rd., Suite 221, Chapel Hill, NC 27517 262-623-4086 Fax: 919-969-1496

Patient (Client) Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Pronouns:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age \_\_\_\_\_\_Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ Gender: Male  Female  Other: \_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May I leave a message? Yes No

Cell Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May I leave a message? Yes No

Work Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May I leave a message? Yes No

E-mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May I leave a message? Yes No

**If Adult:**

Name of Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse/Partner's/Primary Partners’ Name(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Children’s Names and Ages\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If Student/Senior**: Parent/Guardian's/POA’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Best phone # to be reached at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School /College currently attending \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Grade/Year\_\_\_\_\_\_\_\_\_\_\_\_\_

**In case of emergency notify:**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_

Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Financial Guarantor Information (If other than self):**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_

Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Company:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group#\_\_\_\_\_\_\_\_\_\_\_ Policyholder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policyholder’s Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Claims Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_Zip \_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Copay, if known\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State/Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referral Source: How did you find out about us?**

Friend  Insurance Co.  Medical Professional  Pastor  Employer  Internet  Other\_\_\_\_\_\_\_\_

**Religion**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Church Affiliation (if any)**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pastor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do your current difficulties affect your spirituality? Yes  No 

***Adult Intake Questionnaire***

**What is the primary reason you are seeking help at this time?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check all that apply below (if you have any questions about these, please ask your therapist):**

[ ] Fears [ ] Avoidance [ ] Nervous Tics [ ] Panicky feelings [ ] Relationship problems [ ] Seasonal variations in mood

[ ] Anger [ ] Flashbacks [ ] Feeling unreal [ ] Disorganization [ ] Spiritual/religious concerns [ ] Sensitive to noise/light

[ ] Mania [ ] Nightmares [ ] Mood swings [ ] Sexual problems [ ] Difficulties making decisions

[ ] Guilt [ ] Bingeing [ ] Loneliness [ ] No sense of purpose [ ] Driven to perform certain behaviors

[ ] Shyness [ ] Purging [ ] Procrastination [ ] Suspicious of others [ ] Hearing unidentified sounds or voices

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Over the last 2 weeks, how often have you been bothered by any of the following problems?** | Not at all | Several days | More than half the days | Nearly every day |
| 1. Little interest or pleasure in doing things
 | 0 | 1 | 2 | 3 |
| 1. Feeling down, depressed, or hopeless
 | 0 | 1 | 2 | 3 |
| 1. Trouble falling/staying asleep, sleeping too much
 | 0 | 1 | 2 | 3 |
| 1. Feeling tired or having little energy
 | 0 | 1 | 2 | 3 |
| 1. Poor appetite or overeating
 | 0 | 1 | 2 | 3 |
| 1. Feeling bad about yourself – or that you are a failure or have let yourself or your family down
 | 0 | 1 | 2 | 3 |
| 1. Trouble concentrating on things, such as reading the newspaper or watching television
 | 0 | 1 | 2 | 3 |
| 1. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual
 | 0 | 1 | 2 | 3 |
| 1. Thoughts that you would be better off dead or of hurting yourself in some way
 | 0 | 1 | 2 | 3 |
| How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? | Not at all | Some-what | Verydifficult | Extremelydifficult |
| In the past TWO years, have you felt depressed or sad most days, even if you felt okay sometimes? | Yes | No |  | Score: |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Over the last 2 weeks, how often have you been bothered by any of the following problems?** | Not at all | Several days | More than half the days | Nearly every day |
| 1. Feeling nervous, anxious, or on edge
 | 0 | 1 | 2 | 3 |
| 1. Not being able to stop or control worrying
 | 0 | 1 | 2 | 3 |
| 1. Worrying too much about different things
 | 0 | 1 | 2 | 3 |
| 1. Trouble relaxing
 | 0 | 1 | 2 | 3 |
| 1. Being so restless that it’s hard to sit still
 | 0 | 1 | 2 | 3 |
| 1. Becoming easily annoyed or irritable
 | 0 | 1 | 2 | 3 |
| 1. Feeling afraid as if something awful might happen
 | 0 | 1 | 2 | 3 |
|  Total Score:  |  |  |  |  |

|  |
| --- |
| **In your life, have you ever had any experience that was so frightening, horrible, or** **upsetting that, in the past month, you:** |
| 1. Have had nightmares about it or thought about it when you did not want to?
 | Yes | No |
| 1. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?
 | Yes | No |
| 1. Were constantly on guard, watchful, or easily startled?
 | Yes | No |
| 1. Felt numb or detached from others, activities, or your surroundings?
 | Yes | No |

**Mental Health History**

***Has anyone in your family had any of the following conditions? (check all that apply)***

 Depression  Anxiety  Suicide  Bipolar Disorder  Psychosis  Alcoholism  Substance Abuse

***If yes***, please describe the family member’s relationship to you and the problem:

Concern\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Which relatives\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Concern\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Which relatives\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Concern\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Which relatives\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever wanted to end your life?  No  Yes Have you ever attempted suicide?  No  Yes

Do you currently have suicidal thoughts?  No  Yes Have you tried to harm yourself recently?  No  Yes

Do you ever feel angry enough or out-of-control enough to do something you might regret?  No Yes

Do you have now or have you ever had thoughts of killing or seriously hurting someone else?  No  Yes

In the past year, have you slapped, kicked, punched, or hurt anyone?  No  Yes

**Childhood History**

As a child did you have any problems with:

Learning disabilities

Hyperactivity

School fears

Depression

Sexual or physical abuse

 No  No  No  No  No

 Yes  Yes  Yes  Yes  Yes

**Age**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any there other major childhood (0-17 years) school, learning, or emotional problems?  No  Yes

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal History**

Which of the following best describes the family in which you grew up?

 Warm and Accepting Average Distant, Hostile, and Fighting

 1 2 3 4 5 6 7 8 9

Was your family/home/or adult life disrupted by serious illness/accident/death/divorce?

 No  Yes If yes, please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History**

Relationship Status: Single Married Divorced Widowed Separated Engaged Partnered

 Number of years married: \_\_\_\_Total number of marriages: \_\_\_\_ Spouse/Partner’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any children?  No  Yes If yes, what are their names and ages? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How satisfied are you with your current family life?  Very Unsatisfied  Unsatisfied  Satisfied  Very Satisfied

How satisfied are you with the support you currently receive from your family and friends?

 Very Unsatisfied  Unsatisfied  Satisfied  Very Satisfied

Have your current difficulties affected your family/friends/coworkers?  No  Yes

**Previous Counseling or Chemical Dependency Services:**

Have you ever seen anyone or are you currently seeing anyone for:

Individual Therapy  No  Yes Marital/Couples Therapy  N o  Yes Group Psychotherapy  No  Yes Sex Therapy  No  Yes.

Facility/Counselor Name Month/Year Seen Reason Seen Helpful?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  Yes

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  Yes

**Have you experienced any unusually severe stresses during the past year?**  N o  Yes

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Job Satisfaction*:***   Very Satisfied  Fairly Satisfied  Not Satisfied

What is your job/profession?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Highest Degree Completed \_\_\_\_\_\_\_\_\_\_\_\_

Have you ever taken work leave for mental health or chemical dependency problems?  No  Yes

Do you have problems with your work performance or boss?  No  Yes

**Medical/Lifestyle History**

Current health  Poor  Fair  Good  Excellent

Do you have any medical problems or diseases? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you ever have a head injury?  Yes  No Did you ever have a seizure?  Yes  No

If yes, please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you exercise regularly?  Yes  No If yes, how many times per week? \_\_\_\_\_\_\_\_\_

**Medications currently used*:***

Medication/Dose When Prescribed Why Prescribed Prescribing Physician

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you take any herbal medications?**  No  Yes Please name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Hospitalizations (Psychiatric/Chemical Dependency)**

Date(s)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reasons

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospital

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Alcohol use***

How often do you use alcohol?  None  Monthly  Weekly  Daily  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On the days that you drink, how many drinks do you usually have?

 Less than 2  2-5  5 or more

Do you consider it a problem?  No  Yes Do others consider it a problem?  No  Yes

Do you have problems at work/school because of drinking or drug use?  No  Yes

Have you had problems with alcohol in the past?  No  Yes

***Nicotine use***

 Do you smoke or use tobacco now?  No  Yes, how much/day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Have you smoked or used tobacco in the past?  No  Yes

***Caffeine***

 How many cups of caffeinated coffee/tea/soft drinks do you drink per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ***Drug use***

Marijuana:  None  Occasionally  Daily  Weekly

Do you use other non-prescription substances?  No  Yes If yes, what substance?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Legal History:**   None  Litigation  Arrest  Victimization, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***\_\_***

**Are you presently involved in a court case?**  No  Yes

1. I have received a copy of the Crosskey Psychological Services, Inc. THERAPIST-CLIENT SERVICES AGREEMENT and a copy of the Crosskey Psychological Services, Inc. PRIVACY NOTICE. (These forms are available on the practice website at www.LauraCrosskey.com)

**II.**

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Initials/ Date

***(This must be initialed and signed by your first session.)***

I have read, understand, and accept the following by initialing each item:

\_\_\_\_\_ that Crosskey Psychological Services, Inc. may disclose Protected Health Information as necessary to

my insurance company if I want my insurance to be filed. If this is not initialed, I understand that I must

pay in full for services.

\_\_\_\_\_ that Crosskey Psychological Services, Inc. may use Protected Health Information within the practice for the

 purpose of Treatment/Consultation

\_\_\_\_\_ that Crosskey Psychological Services, Inc. may share Information as necessary with my primary care physician.

 If you do not wish information to be shared with your physician initial the "no" block below.

\_\_\_\_ NO, do not share information with my physician

Please initial the following if Crosskey Psychological Services, Inc. staff:

\_\_\_\_\_ may contact you or leave messages at your **home** telephone number

\_\_\_\_\_ may contact you or leave messages at your **work** telephone number

\_\_\_\_\_ may contact you or leave messages at your **cell phone** telephone number

\_\_\_\_\_ may contact you by **e-mail.** If yes, specify address**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I have read, understand, and accept all of the provisions of the Crosskey Psychological Services, Inc. THERAPIST-CLIENT SERVICES AGREEMENT and the Crosskey Psychological Services, Inc. PRIVACY NOTICE.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (Patient/Client or Representative) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient/Client

**THERAPIST-CLIENT SERVICES AGREEMENT**

**Laura Barnard Crosskey, Ph.D.**

**Crosskey Psychological Services, Inc.**